		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0001628

Facility Name: Monroe County Nursing Home

Address: 500 Illinois (Number) Waterloo (City) 62298 (Zip Code)

County: Monroe

Telephone Number: (618) 939-3488 **Fax #** (618) 939-5030

IDPA ID Number: 376006468001

Date of Initial License for Current Owners: 11/14/1950

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 753-3858
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/03 to 11/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	142	Skilled (SNF)	142	51,972	1
2		Skilled Pediatric (SNF/PED)			2
3	69	Intermediate (ICF)	69	25,254	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	211	77,226	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	399	596	4,083	5,078	8
9	SNF/PED					9
10	ICF	34,264	21,242		55,506	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,663	21,838	4,083	60,584	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.45%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/1952

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 4,083

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/04 Fiscal Year: 11/30/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	322,196	27,922	10,166	360,284		360,284		360,284			1
2	Food Purchase		241,997		241,997		241,997	(8,900)	233,097			2
3	Housekeeping	247,291	32,054		279,345		279,345		279,345			3
4	Laundry	105,547	17,006		122,553		122,553		122,553			4
5	Heat and Other Utilities			295,821	295,821		295,821	(1,641)	294,180			5
6	Maintenance	103,579		83,332	186,911		186,911		186,911			6
7	Other (specify):*											7
8	**TOTAL General Services**	778,613	318,979	389,319	1,486,911		1,486,911	(10,541)	1,476,370			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,874,837	174,337	5,432	3,054,606		3,054,606		3,054,606			10
10a	Therapy		1,118	429,004	430,122		430,122		430,122			10a
11	Activities	127,357	4,607	7,509	139,473		139,473	(877)	138,596			11
12	Social Services	58,978		1,645	60,623		60,623		60,623			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,061,172	180,062	455,590	3,696,824		3,696,824	(877)	3,695,947			16
	C. General Administration											
17	Administrative	71,086		81,730	152,816		152,816		152,816			17
18	Directors Fees											18
19	Professional Services			65,129	65,129		65,129	(64)	65,065			19
20	Dues, Fees, Subscriptions & Promotions			22,404	22,404		22,404		22,404			20
21	Clerical & General Office Expenses	236,356	26,026	29,339	291,721		291,721		291,721			21
22	Employee Benefits & Payroll Taxes			976,016	976,016		976,016	(134)	975,882			22
23	Inservice Training & Education			2,725	2,725		2,725		2,725			23
24	Travel and Seminar			13,941	13,941		13,941	(1,907)	12,034			24
25	Other Admin. Staff Transportation			533	533		533		533			25
26	Insurance-Prop.Liab.Malpractice			133,901	133,901		133,901		133,901			26
27	Other (specify):*											27
28	**TOTAL General Administration**	307,442	26,026	1,325,718	1,659,186		1,659,186	(2,105)	1,657,081			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,147,227	525,067	2,170,627	6,842,921		6,842,921	(13,523)	6,829,398			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Monroe County Nursing Home #0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			271,138	271,138		271,138	4,140	275,278			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,677	16,677		16,677	(9,919)	6,758			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,226	5,226		5,226		5,226			35
36	Other (specify):*											36
37	**TOTAL Ownership**			293,041	293,041		293,041	(5,779)	287,262			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,819		78,819		78,819		78,819			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,308	115,308		115,308		115,308			42
43	Other (specify):* Nonallowable Costs			199,474	199,474		199,474	(199,474)				43
44	**TOTAL Special Cost Centers**		78,819	314,782	393,601		393,601	(199,474)	194,127			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,147,227	603,886	2,778,450	7,529,563		7,529,563	(218,776)	7,310,787			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,393)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,140	30		9
10	Interest and Other Investment Income	(8,247)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(81,912)	43		24
25	Fund Raising, Advertising and Promotional	(8,967)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,001)	43		28
29	Other-Attach Schedule See PG5A	(108,396)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (218,776)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (218,776)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Monroe County Nursing Home

ID# 0001628

Report Period Beginning: 12/1/03

Ending: 11/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Public relations expense	$ (4,549)	43	1
2	Pet maintenance	(492)	43	2
3	Bird aviary expense	(1,453)	43	3
4	Medicare lab expense	(10,614)	43	4
5	Medicare Xray expense	(17,181)	43	5
6	Out-of-period legal expense	(64)	19	6
7	Service charges	(1,672)	19	7
8	Allocated Day Care expense			8
9	Activity wages	(877)	11	9
10	Food	(507)	2	10
11	Utilities	(1,641)	5	11
12	Employee benefits	(134)	22	12
13				13
14	Travel & seminar	(1,907)	24	14
15	Prior year expenses	(69,381)	43	15
16	Activity in various small accounts	2,076	43	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(108,396)		49

Monroe County Nursing Home
Provider #: 0001628
12/1/03 to 11/30/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Monroe County Nursing Home # 0001628 **Report Period Beginning:** 12/1/03 **Ending:** 11/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,900)	0	0	0	0	0	0	0	0	0	0	(8,900)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,641)	0	0	0	0	0	0	0	0	0	0	(1,641)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,541)	0	0	0	0	0	0	0	0	0	0	(10,541)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(877)	0	0	0	0	0	0	0	0	0	0	(877)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(877)	0	0	0	0	0	0	0	0	0	0	(877)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,736)	0	0	0	0	0	0	0	0	0	0	(1,736)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(134)	0	0	0	0	0	0	0	0	0	0	(134)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,907)	0	0	0	0	0	0	0	0	0	0	(1,907)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,777)	0	0	0	0	0	0	0	0	0	0	(3,777)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(15,195)	0	0	0	0	0	0	0	0	0	0	(15,195)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Monroe County Nursing Home # 0001628 **Report Period Beginning:** 12/1/03 **Ending:** 11/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,140	0	0	0	0	0	0	0	0	0	0	4,140	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,247)	0	0	0	0	0	0	0	0	0	0	(8,247)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,107)	0	0	0	0	0	0	0	0	0	0	(4,107)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(199,474)	0	0	0	0	0	0	0	0	0	0	(199,474)	43
44	**TOTAL Special Cost Centers**	(199,474)	0	0	0	0	0	0	0	0	0	0	(199,474)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(218,776)	0	0	0	0	0	0	0	0	0	0	(218,776)	45

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V					N/A				2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Dale Haudrich	County Commissioner	Administrative	0.00			<1%		$ None	N/A	1
2	Terry Liefer	County Commissioner	Administrative	0.00			<1%		None	N/A	2
3	Frank Kohler	County Commissioner	Administrative	0.00			<1%		None	N/A	3
4											4
5											5
6											6
7											7
8											8
9	Note: No County Commissioner provided services to the nursing home during the reporting period. No business entity owned by a board member										9
10	conducted business transactions with the nursing home during the reporting period.										10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3		N/A								3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	First Nat'l Bank - Waterloo		X	Renovation	$4,023.00	04/17/00	355,347		04/28/10	0.0600	4,931	2
3	First Nat'l Bank - Waterloo		X	Alzheimer Renovation	$11,083.00	09/15/95	1,329,000		09/15/07	0.0535	10,074	3
4	Bonds		X	New Facility Construction	Varies	09/01/04	9,400,000	9,400,000	08/31/24	0.0453		4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$15,106.00		$ 11,084,347	$ 9,400,000			$ 15,005	9
	B. Non-Facility Related*											
10	Finance charges										1,672	10
11												11
12							Less: Interest income offset				(8,247)	12
13							Less: Non-allowable finance charges				(1,672)	13
14	TOTAL Non-Facility Related						$	$			$ (8,247)	14
15	TOTALS (line 9+line14)						$ 11,084,347	$ 9,400,000			$ 6,758	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999		8
	2000		9
	2001		10
	2002		11
	2003	N/A	12

County facility does not pay real estate tax.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Monroe County Nursing Home COUNTY Monroe

FACILITY IDPH LICENSE NUMBER 0001628

CONTACT PERSON REGARDING THIS REPORT Sandy Wiles, Business Office Manager

TELEPHONE (618) 939-3488 ext. 124 FAX #: (618) 939-5030

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	County facility does not pay real estate tax.		$	$
2.			$	$
3.			$	$
4.		N/A	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? N/A YES N/A NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,250 B. General Construction Type: Exterior Brick Frame Brick & Concrete Number of Stories Two

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Facility operates an Adult Day Care Center. All expenses are adjusted out of the cost report.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	240,075	1949	$	1
2					2
3	TOTALS	240,075		$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	211		1952	1952	$ 362,776	$	40	$	$	$ 362,776	4
5			1954	1954	155,296		40			155,296	5
6			1959	1959	464,584		40			464,584	6
7			1972	1972	1,262,811	31,570	40	31,570		1,031,292	7
8											8
	Improvement Type**										
9	Various Improvements			1979	223,119	5,578	40	5578		143,168	9
10	Various Improvements			1980	12,110	303	40	303		7,472	10
11	Various Improvements			1981	19,476	487	40	487		11,524	11
12	Various Improvements			1982	37,408	935	5-40	935		21,195	12
13	Various Improvements			1983	136,600	3,415	40	3415		73,992	13
14	Various Improvements			1984	242,178	6,054	5-20	6054		242,178	14
15	Various Improvements			1985	25,405	1,270	5-20	1270		24,726	15
16	Various Improvements			1987	66,614	1,318	8-20	1318		63,284	16
17	Various Improvements			1988	6,602		10			6,602	17
18	Various Improvements			1989	32,306	1,086	15	1086		32,306	18
19	Various Improvements			1990	96,200	4,104	5-20	4104		58,983	19
20	Various Improvements			1991	13,393	68	5-20	68		13,393	20
21	Kitchen/Dining Room Improvements			1991	62,884	3,144	20	3144		40,622	21
22	Elevator			1992	103,298	5,165	5-20	5165		64,563	22
23	New Duct Work			1992	4,000	200	5-20	200		2,500	23
24	Flooring			1992	4,200	210	5-20	210		2,625	24
25	Entry Way Improvements			1992	16,415	821	20	821		9,852	25
26	Other Various Improvements			1992	7,135	357	20	357		4,463	26
27	Entrance Addition			1993	521,219	26,453	20	26453		287,847	27
28	Elevator Installation			1993	44,480	2,224	20	2224		24,464	28
29	East Hallway Renovation			1994	41,176	2,059	20	2059		21,620	29
30	Second Floor Sprinkler			1994	29,312	1,466	20	1466		15,393	30
31	Boiler Room Repair			1994	2,732	182	15	182		1,911	31
32	Air-Handler Repair			1994	2,231	149	15	149		1,565	32
33	Electrical Work			1994	7,000	350	20	350		3,675	33
34	Various Improvements			1995	10,289	686	15	686		6,640	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various Improvements	1995	$ 20,355	$ 1,018	20	$ 1,018	$	$ 9,830	37
38	Alzheimers Dining/Activity Area	1996	1,208,699	60,435	20	60,435		513,698	38
39	Heat & A/C Project	1996	83,800	4,190	20	4,190		35,615	39
40	Architect Fees	1996	70,506	3,525	20	3,525		29,963	40
41	Additional Costs	1996	12,811	641	20	641		5,449	41
42	Garden Project	1996	14,350	957	15	957		8,135	42
43	Fire Panel Upgrade	1997	7,503	535	12	535		7,503	43
44	Heaters	1997	8,341	599	12	599		8,341	44
45	Insulated Glass	1997	6,580	470	12	470		6,580	45
46	Cabinet Drywall	1997	4,212	299	12	299		4,212	46
47	Sidewalk	1997	700	47	15	47		350	47
48	Generator	1997	41,462	2,932	12	2,932		41,462	48
49	Painting	1998	24,644	1,232	20	1,232		8,521	49
50	Elevator Motor/Feeders	1998	7,991	399	20	399		2,660	50
51	Flooring - East Wing	1998	1,328	66	20	66		418	51
52	Closet Doors	1998	2,342	117	20	117		712	52
53	Sinks & Faucets	1998	422	21	20	21		144	53
54	Cabinets - 2E & 3E	1998	1,191	60	20	60		410	54
55	Counter Tops	1998	883	44	20	44		297	55
56	Architect Fees	1998	51,048	2,552	20	2,552		16,588	56
57	East end closets	1998	3,465	173	20	173		1,125	57
58	IDPH bid review	1998	2,400	120	20	120		780	58
59	Drywall	1998	19,500	975	20	975		6,338	59
60	HVAC	1998	343	17	20	17		111	60
61	Fire sprinklers	1998	30,294	1,515	20	1,515		9,847	61
62	Water heater	1998	724	36	20	36		233	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,639,143	$ 182,629		$ 182,629	$	$ 3,919,833	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,639,143	$ 182,629		$ 182,629	$	$ 3,919,833	1
2	Painting	1998	746	37	20	37		241	2
3	Plastering	1998	11,709	585	20	585		3,802	3
4	Demolition, site work, asphalt, excavation	1998	33,921	1,696	20	1,696		11,024	4
5	Concrete, precast, flatwork, steel, carpentry	1998	74,300	3,715	20	3,715		24,148	5
6	Millwork, doors, roofing, sheetmetal, sealants	1998	18,960	948	20	948		6,162	6
7	Glass/glazing, drywall, painting/wall covering, flooring	1998	104,080	5,204	20	5,204		33,826	7
8	Toilet, fire protection, plumbing, HVAC, electrical	1998	271,827	13,593	20	13,593		88,354	8
9	Contingency, general, bonds, change orders, contractor's fee	1998	121,885	6,094	20	6,094		39,611	9
10	Painting	1999	31,380	1,177	20	1,177		7,846	10
11									11
12	Air system - east wing	2000	337,536	16,877	20	16,877		75,947	12
13	Painting	2000	4,913	246	20	246		1,005	13
14	Canopy	2000	6,160	308	20	308		1,386	14
15									15
16	Fire alarm	2001	4,797	240	20	240		740	16
17	Architectural inspection	2001	6,119	306	20	306		1,020	17
18									18
19									19
20	Window upgrades	2002	36,187	1,809	20	1,809		4,523	20
21									21
22	Waterproofing Coating	2003	5,447	272	20	272		408	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,709,110	$ 235,736		$ 235,736	$	$ 4,219,876	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 936,655	$ 32,746	$ 32,746	$	5-20	$ 822,063	71
72	Current Year Purchases	77,847	5,560	5,560		7	5,560	72
73	Fully Depreciated Assets	71,977					71,977	73
74								74
75	TOTALS	$ 1,086,479	$ 38,306	$ 38,306	$		$ 899,600	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1996 Ford Bus	1996	$ 42,892	$	$	$	5	$ 42,892	76
77	Resident Care	Van	2003	8,650	1,236	1,236		7	1,854	77
78										78
79										79
80	TOTALS			$ 51,542	$ 1,236	$ 1,236	$		$ 44,746	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,847,131	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 275,278	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 275,278	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,164,222	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	New facility -	$ 864,555	92
93	Under Construction		93
94			94
95		$ 864,555	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions				N/A			4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,226 Description: Copiers - 4,181; dish machine - 1,045
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	826	$ 41,302	$	826	$ 41,302	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		698	34,895		698	34,895	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,798	339,902		6,798	339,902	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				78,819		78,819	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory Therapy	10A(2)					1,118		1,118	13
14	TOTAL			$	8,322	$ 416,099	$ 79,937	8,322	$ 496,036	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Monroe County Nursing Home
Provider #: 0001628
12/1/03 to 11/30/04 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,673,825	$ 1,673,825	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	1,253,861	1,253,861	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	8,549,992	8,549,992	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	52,906	52,906	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Refunds Receivable	7,483	7,483	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 11,538,067	$ 11,538,067	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	20,983	20,983	12
13	Land			13
14	Buildings, at Historical Cost	6,709,110	6,709,110	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,138,021	1,138,021	16
17	Accumulated Depreciation (book methods)	(5,160,082)	(5,164,222)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	751,111	751,111	21
22	Other Long-Term Assets (sp Bond issue cost	282,045	282,045	22
23	Other(specify): Construction in Progress	864,555	864,555	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,605,743	$ 4,601,603	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 16,143,810	$ 16,139,670	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 209,139	$ 209,139	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	229,727	229,727	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,653	3,653	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	1,163	1,163	36
37	Inter-Govt. Unearned Income	469,533	469,533	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 913,215	$ 913,215	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	9,400,000	9,400,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 9,400,000	$ 9,400,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,313,215	$ 10,313,215	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,830,595	$ 5,826,455	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 16,143,810	$ 16,139,670	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,459,986	1
2	Restatements (describe):		2
3	**Prior Period Adjustments**	(152,621)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,307,365	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,523,230	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,523,230	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,830,595	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,069,778	1
2	Discounts and Allowances for all Levels	(652,376)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,417,402	3
	B. Ancillary Revenue		
4	Day Care	4,718	4
5	Other Care for Outpatients		5
6	Therapy	903,438	6
7	Oxygen	42,498	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 950,654	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,928	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,393	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,912	16
17	Sale of Drugs	175,966	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,066	19
20	Radiology and X-Ray	16,866	20
21	Other Medical Services	160,493	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 380,624	23
	D. Non-Operating Revenue		
24	Contributions	1,229,323	24
25	Interest and Other Investment Income***	28,239	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,257,562	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule 19A**	46,551	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 46,551	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,052,793	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,486,911	31
32	Health Care	3,696,824	32
33	General Administration	1,659,186	33
	B. Capital Expense		
34	Ownership	293,041	34
	C. Ancillary Expense		
35	Special Cost Centers	278,293	35
36	Provider Participation Fee	115,308	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,529,563	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,523,230	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,523,230	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility files as part of County return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Monroe County Nursing Home
Provider #: 0001628
12/1/03 to 11/30/04 **Schedule 19A**

XVII. Income Statement

Line 28 - Other Revenue

Equipment rental revenue	41,765
Vending commissions	3,712
New facility fund raiser	989
Miscellaneous	85
	46,551

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,795	2,097	$ 57,360	$ 27.35	1
2	Assistant Director of Nursing	1,918	2,137	51,528	24.11	2
3	Registered Nurses	3,946	4,130	89,588	21.69	3
4	Licensed Practical Nurses	51,231	56,337	958,214	17.01	4
5	Nurse Aides & Orderlies	117,197	125,977	1,363,512	10.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,681	4,045	48,153	11.90	8
9	Activity Director	1,899	2,105	25,631	12.18	9
10	Activity Assistants	10,028	10,933	93,772	8.58	10
11	Social Service Workers	4,491	5,121	58,978	11.52	11
12	Dietician					12
13	Food Service Supervisor	1,787	2,097	33,806	16.12	13
14	Head Cook	13,457	14,969	139,264	9.30	14
15	Cook Helpers/Assistants	18,052	19,473	149,126	7.66	15
16	Dishwashers					16
17	Maintenance Workers	8,626	9,369	103,579	11.06	17
18	Housekeepers	31,742	33,918	247,291	7.29	18
19	Laundry	11,804	13,036	105,547	8.10	19
20	Administrator	2,000	2,080	71,086	34.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,066	18,450	236,356	12.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,355	7,329	79,696	10.87	31
32	Other Health Ca Sch 20A	11,783	13,339	234,740	17.60	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	318,858	346,942	$ 4,147,227 *	$ 11.95	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	226	$ 10,166	1(3)	35
36	Medical Director	Monthly	12,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	10	3,513	10(3)	38
39	Pharmacist Consultant	Monthly	540	10(3)	39
40	Physical Therapy Consultant	102	5,100	10A(3)	40
41	Occupational Therapy Consultant	103	5,155	10A(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	53	2,650	10A(3)	43
44	Activity Consultant	Monthly	1,645	11(3)	44
45	Social Service Consultant	Monthly	1,645	12(3)	45
46	Other(specify)				46
47	Infection Control Consultant	2	94	10(3)	47
48	Dementia Program Consultant	Monthly	1,285	10(3)	48
49	TOTAL (lines 35 - 48)	496	$ 43,793		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Monroe County Nursing Home
Provider #: 0001628
12/1/03 to 11/30/04 **Schedule 20A**

XVIII. Staffing & Salary Costs	Hours Worked	Hours Paid	Total Wages	Ave. Hrly. Wage
Line 32 - Other Healthcare				
Volunteer Coordinator	570	600	7,954	13.26
Staffing Coordinator	2,061	2,192	21,736	9.92
Staff Development Coordinator	1,942	2,097	47,710	22.75
Resident Services Coordinator	2,107	2,388	52,060	21.80
Special Care Director	1,212	1,434	18,171	12.67
Care Plan Nurses	3,891	4,628	87,109	18.82
	11,783	13,339	234,740	17.60

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kim Keckritz	Administrator	0%	$ 71,086
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 71,086

B. Administrative - Other

Description	Amount
Management Performance, Inc.	$ 81,730
TOTAL (agree to Schedule V, line 17, col. 3)	$ 81,730
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Crotzer, Ford, Ormsby &		$
Schraeder	Legal	20,660
Duane Morris	Legal	4,908
Schiff Hardin	Legal	6,167
Schorb & Schmersahl	Accounting	13,983
Altschuler, Melvoin & Glasser	Accounting	7,088
Weil & Bachmann	Accounting	2,032
American Expr. Tax & Bus. Svcs.	Accounting	6,399
ADP	Payroll Services	3,892
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 65,129

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 165,664
Unemployment Compensation Insurance	2,487
FICA Taxes	301,784
Employee Health Insurance	257,735
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	217,663
Employee Retirement & Pension	9,744
Employee Morale	14,285
Employee Drug Testing	4,019
Employee Vaccines	2,635
Allocated to Day Care and disallowed	(134)
TOTAL (agree to Schedule V, line 22, col.8)	$ 975,882

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,218
Health Care Worker Background Check	
(Indicate # of checks performed 87)	1,192
Life Services Network of Illinois dues	7,441
County Nursing Home Assoc of Ill dues	1,470
Miscellaneous Subscriptions	436
Miscellaneous Dues	647
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,404

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedules	13,941
Less: Nonallowable expenses	(1,907)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,034

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Monroe County Nursing Home
Provider #: 0001628
12/1/03 to 11/30/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	65,129
Out-of-period legal expense	(64)
Total (agree to Schedule V, line 19, column 8)	65,065

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4								N/A					
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Monroe County Nursing Home # 0001628 Report Period Beginning: 12/1/03 Ending: 11/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See attached $8,911**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **77,437** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **115,308**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **See Schedule 23A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **8,393**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Schorb & Schmersahl, LLC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **County audit still in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Monroe County Nursing Home
Provider #: 0001628
12/1/03 to 11/30/04 **Schedule 23A**

XX. General Information

2. Trade Association Dues

Life Services Network of Illinois	7,441
IL County Nursing Home Assn.	1,470
TOTAL	8,911

14 Facility operates an Adult Day Care Center. All Expenses are adjusted out of the cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

		Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary		322,196	27,922	10,166	360,284	0	360,284	0	360,284
2. Food Purchase		0	241,997	0	241,997	0	241,997	-8,900	233,097
3. Housekeeping		247,291	32,054	0	279,345	0	279,345	0	279,345
4. Laundry		105,547	17,006	0	122,553	0	122,553	0	122,553
5. Heat and Other Utilities		0	0	295,821	295,821	0	295,821	-1,641	294,180
6. Maintenance		103,579	0	83,332	186,911	0	186,911	0	186,911
7. Other (specify)*		0	0	0	0	0	0	0	0
8. Total General Services		778,613	318,979	389,319	1,486,911	0	1,486,911	-10,541	1,476,370
9. Medical Director		0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records		2,874,837	174,337	5,432	3,054,606	0	3,054,606	0	3,054,606
10a. Therapy		0	1,118	429,004	430,122	0	430,122	0	430,122
11. Activities		127,357	4,607	7,509	139,473	0	139,473	-877	138,596
12. Social Services		58,978	0	1,645	60,623	0	60,623	0	60,623
13. Nurse Aide Training		0	0	0	0	0	0	0	0
14. Program Transportation		0	0	0	0	0	0	0	0
15. Other (specify)*		0	0	0	0	0	0	0	0
16. Total Health Care & Programs		3,061,172	180,062	455,590	3,696,824	0	3,696,824	-877	3,695,947
17. Administrative		71,086	0	81,730	152,816	0	152,816	0	152,816
18. Directors Fees		0	0	0	0	0	0	0	0
19. Professional Services		0	0	65,129	65,129	0	65,129	-64	65,065
20. Fees, Subscriptions & Promotion		0	0	22,404	22,404	0	22,404	0	22,404
21. Clerical & General Office		236,356	26,026	29,339	291,721	0	291,721	0	291,721
22. Employee Benefits & Payroll		0	0	976,016	976,016	0	976,016	-134	975,882
23. Inservice Training & Education		0	0	2,725	2,725	0	2,725	0	2,725
24. Travel and Seminar		0	0	13,941	13,941	0	13,941	-1,907	12,034
25. Other Admin. Staff Trans		0	0	533	533	0	533	0	533
26. Insurance-Prop.Liab.Malpractice		0	0	133,901	133,901	0	133,901	0	133,901
27. Other (specify)*		0	0	0	0	0	0	0	0
28. Total General Adminis		307,442	26,026	1,325,718	1,659,186	0	1,659,186	-2,105	1,657,081
29. Total General Administrative		4,147,227	525,067	2,170,627	6,842,921	0	6,842,921	-13,523	6,829,398
30. Depreciation		0	0	271,138	271,138	0	271,138	4,140	275,278
31. Amortization of Pre-Op. & Org.		0	0	0	0	0	0	0	0
32. Interest		0	0	16,677	16,677	0	16,677	-9,919	6,758
33. Real Estate		0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds		0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles		0	0	5,226	5,226	0	5,226	0	5,226
36. Other (specify):*		0	0	0	0	0	0	0	0
37. Total Ownership		0	0	293,041	293,041	0	293,041	-5,779	287,262
38. Medically Necessary T		0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	78,819	0	78,819	0	78,819	0	78,819
40. Barber and Beauty Shop		0	0	0	0	0	0	0	0
41. Coffee and Gift Shops		0	0	0	0	0	0	0	0
	42	0	0	115,308	115,308	0	115,308	0	115,308
43. Other (specify):*		0	0	199,474	199,474	0	199,474	-199,474	0
44. Total Special Cost Ce		0	78,819	314,782	393,601	0	393,601	-199,474	194,127
45. Grand Total		4,147,227	603,886	2,778,450	7,529,563	0	7,529,563	-218,776	7,310,787

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,673,825	1,673,825
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,253,861	1,253,861
4. Supply Inventory	0	0
5. Short-Term Investments	8,549,992	8,549,992
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	52,906	52,906
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	7,483	7,483
10. Total current assets	########	11,538,067
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	20,983	20,983
13. Land	0	0
14. Buildings, at Historical Cost	6,709,110	6,709,110
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	1,138,021	1,138,021
17. Accumulated Depreciation (book methods)	-5,160,082	-5,164,222
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	751,111	751,111
22. Other Long-Term Assets (specify):	282,045	282,045
23. other (specify):	864,555	864,555
24. Total Long-Term Assets	4,605,743	4,601,603
25. Total Assets	########	16,139,670
CURRENT LIABILITIES		
26. Accounts Payable	209,139	209,139
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	229,727	229,727
31. Accrued Taxes Payable	3,653	3,653
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	1,163	1,163
37. Other Current Liabilities (specify):	469,533	469,533
38. Total Current Liabilities	913,215	913,215
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	9,400,000	9,400,000
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	9,400,000	9,400,000
46.Total Liabilities	########	10,313,215
47.Total Equity	5,830,595	5,826,455
48.Total Liabilities and Equity	########	16,139,670

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	7,069,778
2. Discounts and Allowances for all Levels	-652,376
Subtotal - Inpatient Care	6,417,402
4. Day Care	4,718
5. Other Care for Outpatients	0
6. Therapy	903,438
7. Oxygen	42,498
Subtotal - Anciliary Revenue	950,654
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	-
12. Gift and Coffee Shop	3,928
13. Barber and Beauty Care	0
14. Non-Patient Meals	8,393
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	3,912
17. Sale of Drugs	175,966
18. Sale of Supplies to Non-Patients	0
19. Laboratory	11,066
20. Radiologyand X-Ray	16,866
21. Other Medical Services	160,493
22. Laundry	0
Subtotal - Other Operating Revenue	380,624
24. Contributions	1,229,323
25. Interest and Other Investments Income	28,239
Subtotal - Non-Operating Revenue	1,257,562
27. Other Revenue (specify):	46,551
28. Other Revenue (specify):	0
Subtotal - Other Revenue	46,551
30. Total Revenue	9,052,793
31. General Services	1,486,911
32. Health Care	3,696,824
33. General Administration	1,659,186
34. Ownership	293,041
35. Special Cost Centers	278,293
35. Provider Participation Fee	115,308
37. Other	0
40. Total Expenses	7,529,563
41. Income Before Income Taxes	1,523,230
42. Income Taxes	0
43. Net Income or Loss for the Year	1,523,230

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